MEDPAC Medicare Payment Advisory Commission

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April 16, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Star rating system for Medicare home health agencies

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services proposal to establish a star rating system for home health agencies participating in the Medicare program. The agency has many competing priorities in managing the program, and we appreciate your staff's work in developing this proposal.

Background

CMS proposes to establish a star rating system to help consumers in comparing and selecting a home health provider. The star rating system would grade agencies on a 10-point scale, starting with a half-star for the lowest rated agencies and increasing in half-star increments to five stars for the highest rated agencies. Each agency's star rating would be determined by its performance on the following 10 quality measures:

- Timely initiation of care
- Drug education on all medications provided to patient
- Receipt of flu shot
- Pneumococcal vaccine ever received
- Improvement in:
  - Ambulation
  - Bed transferring
  - Bathing
  - Pain interfering with activity
  - Shortness of breath

- Acute care hospitalization within 60 days of admission

A provider's rating would be determined by converting the score on each measure to a star rating. CMS would use the decile of an agency's score on a given measure to determine the star value for that measure. Agencies in the lowest decile (worst performance) would receive a half-star for the measure, and the star value for a measure would increase by half-star increments for each decile above the lowest. For example, agencies with values in the tenth decile (best performance) would receive 5 stars for that measure and agencies in the 70th decile would receive 3 and one-half stars. An agency's publicly-reported star rating would be the average of the star ratings for each of the 10 measures. Star ratings would be reported for agencies that had a sample of at least twenty episodes for the reporting period and sufficient data to compute at least 6 of the 10 measures. An agency's star rating would be displayed on Medicare's Home Health Compare website; the current proposal does not tie an agency's rating to payment.

Comments

The Commission has long held the position that improving the quality of care that Medicare beneficiaries receive is a vital goal for the program. The Commission appreciates that better information for beneficiary decision making is an important tool in meeting this goal, and most of this letter responds to CMS's request for comments on the proposed star rating policy for home health agencies. However, we first state our position that linking quality outcomes to payment would create stronger incentives for providers to improve quality. Commission analysis has found that hospital readmissions declined since public reporting of these rates began in 2009 and Medicare implemented a Hospital Readmissions Reduction Penalty (HRRP).[1] In our March 2014 Report to the Congress, we recommended the establishment of a parallel readmissions penalty for home health agencies, and this may offer an alternative path to quality improvement that would more directly influence provider quality.

For both payment policy and public reporting, the Commission favors the use of a parsimonious set of outcome measures for evaluating quality in the Medicare program. The six outcome measures in the proposed HHA star rating policy (i.e., the five measures of patient improvement and one hospitalization measure) would be appropriate under this principle. However, we do not support the proposed inclusion of four process measures in the star rating system for two reasons. First, the proposed process measures seem to be based on the expected basic standards of care for an agency serving Medicare beneficiaries, and using them as distinguishing quality measures does not seem appropriate. They may be more appropriate for other program guidance, such as the Conditions of Participation. Second, a substantial body of research has found little or no association between providers' performance on process measures for a given condition and their performance on outcome measures, such as mortality and readmission rates, for the same

[1] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

conditions.[2] These findings suggest that many of the process measures available today may have a theoretical connection, or evidence from small, highly controlled clinical trials, between performance on them and improved outcomes for patients, but that link is diminished or non-existent under clinical practice conditions. This research primarily relates to hospitals' performance, but the same cautions likely hold true for other provider types that treat a broad range of clinical conditions, including home health agencies.

An important goal of home health care is the prevention of unnecessary hospitalizations. The proposed rating system would include an acute care hospitalization measure as one element, and Medicare may want to consider giving this measure additional weight in any rating system. In addition, the program should consider modifying its measure to include all hospitalizations that occur while a patient is in home health care, not only those that occur within the first 60 days after admission to home health.

Under the proposed star rating for home health agencies, the benchmark for each star value would be determined concurrently in a year, and agencies would not know in advance what level of performance is necessary to attain a given star ranking on a measure. In other Medicare quality programs, such as the HRRP, the Commission has favored using performance benchmarks that are fixed in advance of the performance period. The Commission favors fixed benchmarks because they provide a clear signal to agencies about the level of performance necessary to achieve a given ranking, and also help agencies target performance improvement efforts. Ranking agencies on a relative scale can also result in measures that are less useful when agency performance is very high on average or the absolute differences in performance between agencies are small. In these cases, the differences in performance among agencies with different star rankings may be too small to warrant different ratings. CMS required that a measure exhibit some variation in performance to be included in the star rating system, but the analysis provided does not establish that the differences in performance between agencies of different decile ranks will be significant at the quality measure level. The use of fixed thresholds with reasonable intervals between different star levels would address these issues.

CMS also needs to consider two technical issues to ensure the accuracy and completeness of the rating system. First, there are many small home health agencies with inadequate sample sizes to be included in the rating system. These agencies should be included to the extent possible, such as by pooling multiple years of performance data.

Second, the appropriate coding of conditions and functional performance has been an issue in the Medicare home health prospective payment system. In prior analysis, CMS has concluded that over 90 percent of the increase in reported case-mix index has been due to changes in agency coding practices, rather than a real increase in the health status of the beneficiaries served by home health agencies. As CMS develops star rating systems and other policies that could eventually feed in to pay-for-performance, it should develop appropriate safeguards to protect the accuracy and integrity of reported data.

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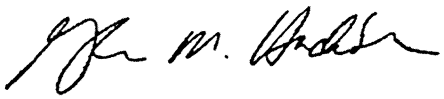
[2] Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, the Commission's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/ec/r